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ABSTRACT

Six papers focus on aspects of the Macomb (Illinois) 0-3 Regional Project, a rural home based program to assist parents and their handicapped and high risk infants and toddlers. The first paper discusses the role and operation of home visits, with emphasis on the functions of the child development specialist (CDS). The second paper describes the project's undifferentiated staffing patterns, while the third examines the use of a mobile unit in delivering services to rural areas. Cost information for the unit is broken down. The origin of the baby buggy as the project's logo is recounted in the fourth paper. The development and implementation of activity plans in home visits are considered in the fifth paper, while the final paper addresses the issue of toilet training. (CL)

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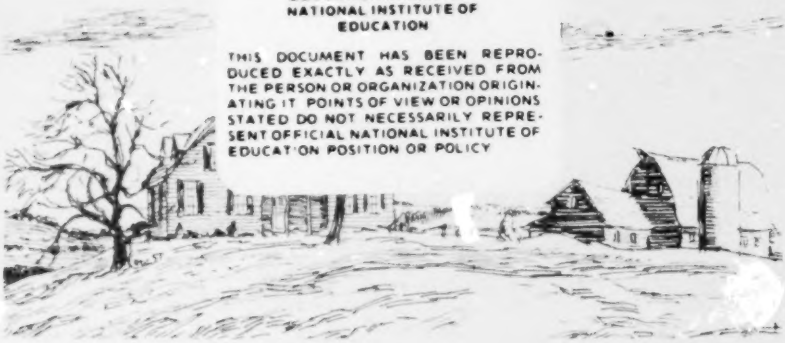

Your House or Ours

Home Visits for Rural Handicapped Infants, Toddlers, and Their Parents

Baby Buggy Book No. 3

May, 1978

EC122403

Macomb 0-3 Regional Project, Patricia L. Hutinger, Ed.D., Director

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Why Early Intervention?

Often people ask, genuinely puzzled, "What can you possibly do to help a tiny baby? Wouldn't it be better to wait until the baby is at least three years old or so to work on development?"

The first three years of life are the period of the most rapid growth and development in the entire life of an individual. Much can be done to help stimulate growth and development in a typical baby during those years. Of even greater importance, perhaps, is the stimulation of growth and development in a high risk, delayed, or handicapped child in order to compensate for or overcome difficulties presently being experienced, as well as to prevent future problems from occurring.

Resources and services available to handicapped and high risk children from birth to three, and to their parents, are often limited in isolated rural communities. Families who live in areas eighty to one hundred miles away from any large population center frequently cannot find the information, professionals, facilities, or support they need when handicapped or high risk children are born. Since the first three years of life are a time when many important developmental abilities are acquired, it is especially important that a child facing a physical or mental impairment or a high risk environment be given the finest educational beginning possible. The highest quality of medical care and educational opportunity often is available to those residing in suburban areas, while those residing in rural areas, who also exhibit high risks and handicaps, receive the least adequate care and educational opportunity.

Not every child reaches his/her potential for growth and development during the first three years of life. Some are born with a physical or mental impairment; others are born prematurely and often experience difficulty in "catching up" in development; still others are born into high risk

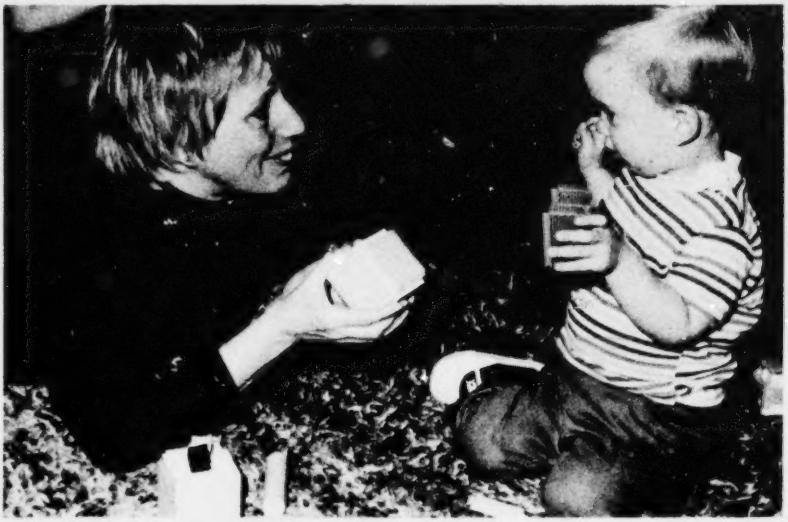
environments in which parents or caretakers either are unaware of the expected patterns of growth or development in a child or choose to ignore any suspected problems their child might have. "The rest of my kids were slow in walking too," a seemingly untroubled mother will say of her child's suspected delay in motor development. "He'll outgrow it" is another favorite cliche' frequently used by relatives, friends, and even professionals when faced with signs of delay or impairment of some kind in infants.

Because of the conditions and problems related to services in rural areas, the Macomb 0-3 Regional Project, a Rural Child/Parent Service, was developed as a model for working with handicapped and high risk infants, toddlers, and their parents, who live in rural communities in an area of West Central Illinois. As a result, existing services to children and their parents are of a higher quality than they were before the Project began; in addition, services now exist where formerly there were none. Community and regional awareness of the Project's activities has developed into a well-functioning referral network and resource system, albeit at times informal in nature.

Who Provides the Services?

A professional staff of well-trained, flexible, and sensitive individuals was considered essential in developing and carrying out a home-based delivery of services. Child Development Specialists in the Project either have degrees in Special Education or Early Childhood. They also are committed to professional growth, taking advantage of supplementary course work and in-service in areas of need (e.g., the Early Childhood majors have taken extra course work in Special Education and vice-versa).

An undifferentiated staffing pattern for Child Development Specialists (CDSs) has worked well in rural areas. Each CDS has been trained to serve as child evaluator, parent involvement initiator, activity planner for child and parent, coordinator with helping agencies, resource person, transportation provider (when necessary), and friend. The flexibility of the CDS has been a key component in serving children who exhibit a variety of anomalies ranging from severe and profound handicaps to slight developmental delays. In a single rural area there may be one or two cerebral palsied children, a blind child, a deaf child, a Down's child, as well as many children with general developmental delays. The CDS must possess (or acquire) the skills and knowledge to effectively handle such a varied caseload. In an urban area, a classroom for a particular handicapping condition may be a feasible strategy; however, such specialization is far more difficult, if not even impossible, to achieve in rural communities. The Macomb 0-3 model reflects a varied handicapped population and has developed the training techniques to make the undifferentiated CDS staffing pattern possible.



Home Visits - A Partial Solution

Early intervention with infants takes place in two major types of programs: center-based and home-based, or some combination of the two. A center-based program for infants residing in a rural area with scattered population is not generally practical. On the other hand, a home-based delivery of services to the family of a delayed, high risk, or handicapped infant on a weekly basis seems to provide an effective means of reaching both the child and the parent or caretaker in the most natural of all surroundings, the home.

The home visit is a basic strategy in the Macomb 0-3 Regional Project's service delivery. Home visits require that the CDS do the traveling (frequently in the Project's "house on wheels" mobile unit) rather than transporting the child for many miles to a common program site. The Project was developed under the basic assumption that it was more effective both in terms of cost and participation to take services to the families in rural communities where even transportation itself can be a major problem. By working at home with the infant and parent, the Project solved many of the problems involved with bringing a young child to a center—long bus rides, warming bottles, changing diapers, carting around the infant's necessities, bundling up the child in cold weather, and exposure to a variety of illnesses and temperature changes. At home everything is close at hand, from bottles to daipers. Carrying the educational materials to the home places a greater burden (literally) on the CDS; however, it relieves some of the stress related to transportation and coping with daily problems for the parent.

After a child has been accepted into the program, home visits are conducted by CDSs on a weekly basis. If the child's delay is slight, visits are scheduled less frequently. These visits, approximately one hour in length, consist largely of the following: observation of both child and parent and the reciprocal action between them; interaction between CDS and parent; interaction between CDS and child; pin-pointing a specific behavior for careful attention (either child behavior or parent behavior or perhaps both); and the implementation of a jointly determined appropriate activity.

Parents Are Important

No early intervention program can be successful without the active involvement of the child's family. Parents are the ones who provide an ongoing daily program to reinforce and sustain any outside help they may receive. An understanding of the orderly sequence of development taking place in the early years helps parents guide their delayed or handicapped child from one stage to the next. In a home-based program the CDSs help parents to be aware of developmental stages. The parent is also encouraged to learn to divide everyday activities into steps that are small enough for his/her child.

Staff of the Macomb 0-3 Regional Project reasoned that since the parents are with the child far more than a program-related person can ever be, it was essential to train the parent to function as effectively as possible with his or her child. Home visits became the primary vehicle for such training. If the parent has the knowledge and skills to work with his or her handicapped child, then positive experiences can occur when a trained professional is not present. The potential for providing these experiences for the handicapped or delayed child is increased in proportion to the skills and understanding acquired by the parent. Even in today's changing society, parents remain the most important people in the young child's life.

Parents are frequently the primary caretakers; however, when a parent works, the importance of other primary caretakers must be recognized. A primary caretaker may be a grandparent, another relative, a paid babysitter, or a teacher in a day care center. The Macomb 0-3 Regional Project staff assume that a home visit must be made to the primary caretaker, so sometimes home visits are made in places besides the home. In such cases, every effort is made to include the parent at another time, in order to provide that parent with information regarding the child's activities, needs, and progress, as well as to find out what the parent expects and desires for his/her child.

Intake Procedures

Before the initial visit can take place, a referral must come from some source. In the Macomb 0-3 Regional Project referrals are received from many different sources, including doctors, parents, hospital staff members, friends, ministers, the Public Health Department staff, members of the Division of Children and Family Services, and other interested persons. Most referrals are received by phone at the Project office; however, referrals are often given to a Project member after a presentation of the Project to community organizations, or after a visit to professional helping service agencies.

Upon receiving the referral, the staff member records all information. It is important to gather as much information as the source can give about the child, family, condition, and situation. Pertinent information is noted on a caseload-referral card. Then, the staff member contacts the referral by phone, if possible, or writes a letter if the address is known, to set up a time to explain the Project to them. If there is no phone or the address is unknown, a drop-in visit with the family is necessary. In rural towns a short stop at the grocery store or gas station usually results in the location of a family. It may be necessary to go back to the house several times, however, before finding the family at home. During the first contact, whether by phone, letter, or face-to-face, the CDS introduces herself and identifies her connection with the Project. The referral source is used, if it is not confidential. The CDS may say, "Alice Jones suggested I call you," and then go on to explain why. A very brief description of the service is given; then the CDS asks to make an appointment to come and explain the Project in more detail. Of particular importance in a rural area is the soliciting of accurate, detailed information as to the address and directions to the house. Familiar landmarks, such as gas stations, grain mills, and trailer courts, help the CDS discover the location of a referral in a maze of unmarked roads and houses. (Mailboxes with the family name are regarded as a real plus in directions to a rural house or trailer!) If the appointment for an initial visit to explain the Project at greater length is not scheduled within several days, the CDS sends a card to remind the family of the date.

What Happens in a Home Visit

Depending upon the child's particular handicapping or delaying condition, the home visit occurs once a week, or once every two to four weeks. A child who exhibits a pronounced handicapping condition will be visited each week; a child who is only slightly delayed in one area of development may be seen only once every two weeks, or even once a month in the case of high risk children monitored by the Project staff. In some cases a physician or the public health nurse refers a child who is considered "high risk" to the Project even though no delays are apparent.

Those children are monitored once a month (often at a sharing center, rather than in a home visit). Children originally considered "monitors" but who demonstrate developmental delays in one or more areas are subsequently rescheduled for more frequent home visits.

Differential treatment of children, dependent upon the child's diagnosis, is an important part of services in rural communities where those children referred and seen exhibit a wide spectrum of severity and categories of anomalies. In larger population centers, a program exclusively for physically handicapped children is feasible, but such a program is not feasible in the rural areas.

Home visits have similar formats but differ in content, depending upon the child being seen. Usually the home visit lasts about an hour, and includes time for talking with the parent, activities for the parent and child, as well as some time for periodic assessment. A more detailed schedule for home visits may be found in The Home Visit Training Manual.

Since the home visit becomes a routine part of the child's life, the primary caretaker is included in every home visit. Carry-over of activities throughout the week is important and necessary. In a home visit, the CDS models effective ways to work with the child through both activities and interactions with the child. Demonstrating ways to work with a child is often as effective as explaining how to do things. Again, one of the most important goals of the Project is to help the parents be more effective in their interactions with children.

In a home visit, the CDS and primary caretaker work together as a team, developing a close relationship with one another. In time, most parents and caretakers come to share their concerns and problems with the CDS,

once mutual trust and acceptance is established. Parents develop a sense of the importance of taking part in their child's education. They learn the value of specific activities in helping their child reach a goal. Through interaction with both the child and CDS, parents develop a more realistic view of their child's abilities. During the course of the home visits, the parent learns to be a keen observer of his or her child's responses and reactions to different stimuli and situations. The parent begins to develop the ability to interpret what the child's behavior means at a variety of levels.

What the Child Development Specialist Does in Home Visits

The undifferentiated staffing pattern referred to earlier indicates that the Macomb 0-3 Regional Project's CDSs do many things—each one is virtually a "jack-of-all-trades." Generally, they accomplish the following with each family:

1. They arrange for medical evaluations, setting up appointments, providing transportation where necessary, and even suggesting sources of financial aid to families.
2. CDSs evaluate the child by means of assessment tools, individual observation, and information obtained from the parents and physicians.
3. The CDSs accompany the occupational therapist (OT) on selected home visits; they carry out recommendations made by the OT or physical therapist concerning the individual child.
4. Based upon their observations and evaluation, the CDSs and parents set goals for the child in a variety of areas: gross motor, fine motor, cognitive, language development, and self-help skills.
5. They plan activities to meet the goals set for the child, and carry out the activities with the help of the parents or primary caretakers at weekly home visits.
6. The CDSs aid the parents in dealing more effectively with their children, providing activities, modeling behavior, and bringing reading materials.
7. When a child approaches his/her third birthday, the CDS arranges a staffing where necessary to provide the most appropriate educational placement for the child. Local school personnel are contacted and take part in this staffing.

A Child Development Specialist does all the above things and many more to provide support and aid to parents in helping them become the most effective parents possible to their children.

Where Weekly Visits Take Place

Since it is assumed that the home is a valuable resource, weekly visits usually take place in the home. Sometimes, however, home visits occur in the mobile unit (the Project's "roaming home"), or outside when the weather permits. In some cases weekly visits take place in day care centers or in babysitters' homes.

The home environment is familiar to the infant and parents, so both are usually at ease and comfortable there. When child and parent feel secure in the environment, the CDS is more likely to see representative behavior and language. While she is in the child's home, the CDS demonstrates through concrete examples ways in which the parents can arrange the home for the benefit of their child's development while also alleviating undue worry for the parents. The parent is shown that valuable objects can be placed up high, wall sockets covered, plants put out of reach, and cleaning aids stored in a safe place. Such suggestions can either be made by the CDS or actively carried out as part of the home visit. Children need large or at least open spaces for play. The CDS and parent can work together on arranging the furniture in a specific room so that it is adapted for both parents and child.

Not all homes are large and/or beautiful, or easy to work in. Sometimes the CDS may find the home or trailer too small a space in which to work with parents, child, and siblings. In such cases, the mobile unit is used. The CDS drives to the home, where the parent(s) and child come out to the mobile unit. A home visit in the mobile unit provides an

opportunity for the parent and child to get out of the house. The mobile unit also functions as a neutral area. Parents who are unwilling for one reason or another for the CDS to come into the home often are willing to come out to the unit to work with their child.

The mobile unit serves as an example of how an area can be arranged to accommodate the needs of both adults and small children. If the parent is hesitant to try "messy" activities inside the home, those activities can easily be carried out in the mobile unit. Frequently parents don't want to get their house or their child dirty. These parents can be more comfortable in the mobile unit during a pudding painting session, for example. Such a session demonstrates how one can go about managing a situation which is developmentally appropriate for the child, but environmentally distressing for the parent. A drop cloth, paper towels, water, and a smock can make all the difference in the outcome of a messy activity. The parents may never have thought of setting up the activity using materials that aid in the performance of the activity as well as in cleanup afterward.

When the weather is nice, the CDS, child, parents, and siblings can hold the home visit outside. A back yard or nearby parks provide excellent places in which to explore textures, smells, sounds, and sights not found in the home. Bubbles blow in the breeze and the grass tickles bare feet in the outdoors. Things moving outside—cars, people, and trees—are all stimulating to children. At the same time, parents learn to use on their own such opportunities for development in their child.

Some Project children are seen weekly in their daily environment, a day care center or babysitter's home. Here it is the teacher, aide, or babysitter who implements the activities suggested and demonstrated by the CDS. In these cases, as in all Project activities, an attempt is made to keep the

parent(s) informed of the child's progress and involved in follow-through activities at home.

Home Visit Components

Necessary components for a home visit include (1) preparation and planning, (2) the actual home visit activities, and (3) evaluation and planning for subsequent home visits.

Home visits are carefully planned and prepared for by the CDS. Activities appropriate to the child's level of development are selected to meet the child's individual bi-yearly goals as previously determined by the CDS and the parents. A detailed description of how programs are planned and activities selected for individual children may be found in the Home Visit Training Manual. Although careful planning takes place, the CDS never loses sight of the importance of flexibility and the inevitability of a sudden change in plans being required. A somewhat rigorous session in moving a child through an improvised obstacle course, for example, may not be the most desirable activity for the week when the CDS is greeted at the door by a distraught looking mother holding a feverish child. At times such as these, the ever-flexible CDS either reschedules the home visit or scuttles the plans for the day and makes the most of a chance to sit quietly and talk with the parent about any questions, anxieties, or desire for further information she might have.

Activities at home visits vary from week to week, from individual to individual. The CDS brings toys, books, records, an unbreakable mirror, or other materials with her to the home for the planned activities. At periodic intervals, assessment tools (Alpern-Boll, REEL, and the Uzgiris-Hunt

Ordinal Scales) are administered to the child. A specific activity based on the objectives in the child's bi-yearly goals is demonstrated by the CDS and provided for the parent and child to work on during the following week; in many cases, the parent is asked to chart the child's progress to be reviewed by the CDS and parent together the following week before moving on to the next activity. Activities are based on the child's developmental age, not his chronological age. If an objective is too difficult for a child, activities are broken down by task analysis. A detailed description of activities and procedures in a typical home visit may be found in the Home Visit Training Manual.

After each home visit is completed, the CDS informally evaluates the day's activities, often while en route to the next scheduled home visit. Was the activity geared to the child's level? Did the parent allow the child to work through the activity and encourage his/her efforts? Did the CDS explain the purpose of the activity clearly and model effectively for both parent and child? Will the parent be able to chart this activity relatively accurately? Before planning next week's visit, evaluative questions such as these are addressed by the CDS. A listing of criteria for evaluation of home visits is contained in the Home Visit Training Manual.

Home visits, whether in "your house or ours," involve careful planning, a willingness to participate on the part of the parent, a flexible approach on the part of the CDS, and as objective an evaluation as possible. Home visits constitute a basic strategy in the Macomb 0-3 Regional Project's service delivery to rural families of delayed, high risk, or handicapped infants.

macomb 0-3 regional project

rural child-parent service

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Rural Child/Parent Service
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A rural area often does not have the special services that a young child needs. If the services are there, the child and his parents may have to travel many miles to take advantage of them. This situation creates some unique problems for the Child Development Specialist (CDS) in the Macomb 0-3 Regional Project, a home-based project which serves handicapped, high risk, and/or developmentally delayed children, ages zero to three, and their parents who reside in a rural area. Delivery of services in a rural area calls for a staff of sensitive, flexible, adaptable individuals--in other words, an undifferentiated staffing pattern.

Roles and Responsibilities of a CDS

An undifferentiated staffing pattern suggests that the CDSs do many different things. Because the Macomb 0-3 Project is a home-based project, the home visit is a key to the success of the interaction between the CDS and the individual family. Conducting the weekly, semi-monthly, or in some cases monthly (high risk monitors) home visits requires a variety of skills. Each CDS serves as a child evaluator, initiator of parent involvement, activity planner and implementer for child and parent, resource person, model for parents, good listener, and friend during the course of a home visit. Though home visits are carefully planned by the CDS beforehand, expecting the unexpected is nonetheless the watchword. From meeting a father clad in long underwear to gently informing a retarded mother that she ought not to trade her baby boy for someone else's baby girl, unusual situations arise daily which require common sense, resourcefulness, understanding, and a sense of humor on the part of the CDS.

Having a variety of talents is helpful to a CDS in areas other than home visits. The CDSs working in the Macomb 0-3 Project have all been trained to conduct sharing centers. These centers are places where parents of typical and atypical youngsters come together with their children and the CDSs to share experiences, activities, and ideas for mutual growth. It is the CDS's responsibility to initially plan appropriate activities for the children that parents can share, to set up the center in such a way that parents and children can join in as soon as they arrive, to welcome parents and children and make them feel comfortable, to encourage parents to interact, to provide a study group as part of the center, and to plan and provide a quick, nutritious shack for the parents and children. In addition, the CDS must make arrangements for the center site and be sure that everything has been put back in order before she leaves.

The CDSs from the Macomb 0-3 Project have also participated in conducting the WADE (Water Activities for Developmental Enhancement) program. This program is held in conjunction with the local YMCA Mom 'n' Tot swim program. Here, the CDS needs to make sure all parents are in the water with their children. Then she may go from child to child, showing the parents specific activities for their child's development. She may also organize activities for several children and

their parents. The Project CDSs have at times provided ancillary services for WADE program participants, such as furnishing transportation to and from the YMCA, helping parents who have more than one child in the program, and finding a swimsuit for an interested parent who doesn't have one to wear.

The Macomb 0-3 Project is a practicum site for university students majoring in Speech Pathology, Early Childhood Handicapped Education, and Special Education. Speech Pathology graduate students accompany CDSs on home visits. The students are given the chance to observe and later to take part in the home visit. They are provided by the CDS with specific information and training that is needed in dealing with young children. The CDS helps the practicum students develop the delicate balance between interacting with the child, while allowing the child to do what he wants within the framework of the activity provided. It is also important for the practicum students to learn how to work with the parents of the children and to maintain confidentiality. The CDS gives information to the student and models behavior in order to help the student develop rapport with parents.

The CDS performs many ancillary services for the parents of Project children. She may refer the parents to a cooperating agency if the need is apparent, and act as a mediator between the agency and the parents. For instance, the Macomb Project has referred families to psychological counselors and social services, including the Public Health Department, the school social worker, and the Division of Children and Family Services. Parents sometimes ask the CDS for help in obtaining other services. If parents feel that their child needs a specialist or specific testing, they may ask the CDS for her recommendations. Then it is the responsibility of the CDS to give them the most reliable information possible. As specialized treatment is often costly, the CDS frequently helps find a service such as Crippled Children or United Cerebral Palsy to defray the cost of medical care. Service organizations such as the Lions or Kiwanis are also solicited on occasion to fund special equipment.

In working with handicapped or delayed infants, if the CDS suspects the need for a specialist (such as a vision consultant, audiologist, or orthopedist), she must first determine if there is one within reasonable traveling distance (a radius of 100 miles). Upon locating the specialist, the CDS then becomes a coordinator and sometimes also a transporter, bringing the child and specialist together. If there is no specialist in the area, the CDS has two alternatives. First, she may find an agency that sponsors a consultant specialist. For example, in the Macomb 0-3 Project area, an orthopedist is scheduled in the Crippled Children's Clinic every other month. The other alternative, when appropriate, is for the CDS to acquire the necessary information to help families in a variety of problem situations.

Specialized information may be obtained in several ways: in-service training for the staff; attendance at seminars and workshops; or research to discover written material to bridge the gap for parents of children with specific problems. For example, the Macomb 0-3 Project has provided in-service training for its staff and interested individuals in the areas of physical and occupational therapy, visual impairment, cleft palate disorders, reflex testing, and infant appraisal. In addition, one or more staff members have attended seminars on hearing impaired children, speech and language disorders, assessment of premature infants, and oral motor function and dysfunction. If the information needed to solve a special problem can be found in available reading material, the CDS checks with appropriate resources to obtain the necessary information. She then reads the material carefully before implementing it with the child and sharing it with the child's parents.

It is important to note that obtaining information in a specialized area does not make the CDSs experts in any of the given areas. The knowledge and skills acquired, however, do serve to provide the CDSs with enough expertise to enable them to guide parents in following prescribed treatment programs.

Environmentally deprived families pose different problems in the CDS's efforts to stabilize the family. Lack of food or a poor environment (cold, dirty, cramped, drafty) may contribute to a child's being ill much of the time. The child may also be subject to more frequent injury because of the safety hazards found in many homes. The child may receive very little stimulation, causing him to be delayed in development. With an environmentally deprived family, the CDS may contact the appropriate agency in order to provide the family with a homemaker or social worker if needed. The CDS may also find needed items such as food, toys, and clothing for the family. Above all, the CDS ideally is a friend to the family. This relationship enables her to more effectively counsel them in the importance of practicing good nutrition, having a clean, safe house, and providing stimulation for their child. The CDS also offers as many suggestions as possible for accomplishing these goals on a severely limited budget.

In addition to the roles described above, the CDS may also find herself involved in activities not directly related to delivery of services to children and parents. These activities have involved the Macomb Project CDSs in taking videotapes and pictures, developing slide/tape presentations, writing dissemination materials (such as the Baby Buggy Papers), writing guides for parents, and helping in the production of grant proposals and progress reports. The CDS may also be involved in dissemination of information. The Macomb Project staff members have made presentations both locally and on a wider scale. Locally, dissemination activities have included presentations to area organizations, radio and TV interviews and participation in a health fair and an Association for Childbirth Preparation and Family Life conference. On a larger scale, staff members have made presentations at the Association for Childhood Education, Midwest Association for the Education of Young Children and the National Association for the Education of Young Children.

Advantages of an Undifferentiated Staffing Pattern

There are many advantages to having multi-talented CDSs in a rural area. First of all, a competent CDS can provide some of the services that children need which are not available elsewhere. This in turn cuts down on consultant costs, leaving more money available for other needs of the children. There are several advantages that a well-trained CDS can offer directly to the parents. If the CDS can perform a service directly, she lessens the confusion of having outsiders come into the family's home, thereby also eliminating the problem of distrust of strangers that is found in many homes. The competence of the CDS in a variety of tasks also gives the parents she visits confidence in her. They then are more likely to follow her advice and work with her more willingly in becoming effective parents to their children.

Finally, a well-rounded CDS staff simplifies the work that must be done in an infant project. Since the staff members take part in many activities outside of direct delivery, they have a good idea of what is going on in the whole operation of the Project. When it is necessary, one CDS can fill in for another, whether in delivery of services or in another capacity. Therefore, finding a CDS who can successfully perform a task does not depend on ability, but on who has the most time, is available at the right time, and is willing to do it. The Macomb 0-3 Project staff members still maintain their individuality. Each CDS has unique talents. Therefore, when a job arises that not everyone can do, the "expert" in that area is called on to take over.

At this point the reader may be wondering where and how to obtain a staff of multi-talented, flexible individuals such as those who have been described. The CDSs in the Macomb 0-3 Regional Project are professionals chosen for their knowledge and skills, flexibility, and good rapport with people. They have individual strengths and weaknesses, however. Many of the skills needed for work with handicapped young children and their families in a rural area are not innate but are acquired in the process of the job itself and from each other. A willingness to upgrade professional skills, to be open to new ideas, and to maintain a sense of humor, come what may, have led to the formation of effective CDSs in the infant project. An undifferentiated CDS staff requires time, training, and patience, but in a rural area, it is well worth the effort.

macomb 0-3 regional project

rural child-parent service

Macomb 0-3 Regional Project
Rural Child/Parent Service
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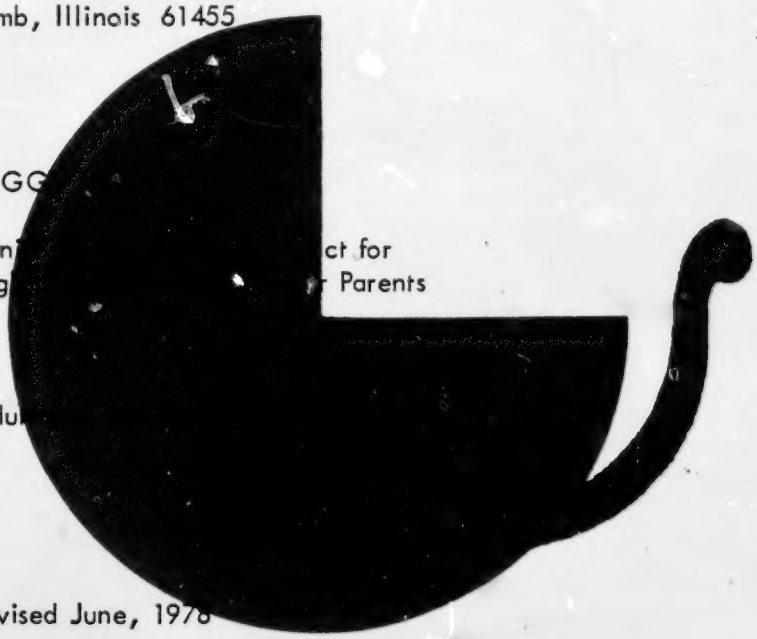

BABY BUGG

Using a Mobile Uni ct for
Handicapped and Hig Parents

Patricia L. Hu

Revised June, 1978

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USOE-BEH Grant No. G00-75-00234 Project No. 44 AH 50417

Since a rural project for handicapped children under the age of three is, of necessity, spread across a large geographical region, the Macomb 0-3 Regional Project was funded to develop a working model using a "room on wheels" which travels around the countryside. In the Project, the mobile unit is taken to the scattered rural families rather than attempting to gather all the families and children in a central location for various activities. The purpose of this paper is to describe uses of the mobile unit, to give information on specifications and maintenance, and to present cost figures.

Use of the mobile unit is an integral part of the delivery services to rural handicapped young children and their families in the Project. A member of the First Chance Network of the Handicapped Children's Early Education Program, funded by the Bureau of Education for the Handicapped, the Macomb 0-3 Regional Project is a model home-based program for the education/remediation of handicapped, high risk and/or developmentally delayed infants, ages birth to three, and their families, who reside in a rural area. The Project is located in the College of Education at Western Illinois University in Macomb, Illinois.

Underlying objectives of the home-based Project include provision of on-site services to young children and their families; achievement of a high rate of participation among families scattered in a rural area with few centralized helping services; and attainment of cooperation, responsibility, and effectiveness on the part of parents as a result of the direct on-site service delivery. Parents of handicapped infants sometimes find that the extra burden of transporting the children to a central location is more troublesome and tiresome than staying home with the child. Travel is also tiring for the child and does not provide optimal conditions for implementing the desired improvement of the child's behavior. "Bringing the mountain to Mohammed" by means of a mobile unit results in effective service delivery in rural communities.

The concept of using a mobile unit for the delivery of services is not new. There have been a variety of successful uses of mobile units in the past. Research laboratories for psychological testing were constructed in mobile units by Sidney Bijou and Leslie Malpass in the 1950's. Medical/lab services have been delivered via a mobile unit by the Red Cross (bloodmobile), the American Tuberculosis Association and the American Lung Association (chest x-rays). Jack Wilmore at the University of California, Davis, used a mobile unit as a traveling exercise physiology lab. Bookmobiles have long been an effective means of providing reading materials to rural populations, while "traveling classrooms" have also been used in Appalachia and other remote areas of the country. Commonly, mobile units have been used for transportation, whether of senior citizens, handicapped individuals, or persons in need of special services.

Uses of the Mobile Unit

The uses of a mobile unit in the 0-3 home-based Project are varied. In the delivery of on-site services to families living within a 50-mile radius, the mobile unit provides space for some home visits as well as transportation to the homes for the Child Development Specialist. When the mobile unit is used by the staff on an initial visit, it attracts attention and generally elicits a favorable response from the new families.

In subsequent home visits, the mobile unit provides a model demonstration area for work with the child and parent. There is no pressure upon the parent to provide adequate space or an orderly household. Some Project families live in trailers with less floor space than that of the mobile unit. If two Project families live relatively close to each other, the mobile unit is used to hold small sharing centers. There parents, children, and siblings come together with the Child Development Specialist to participate in developmental activities and educational experiences.

The mobile unit provides a neutral territory, an important factor in working with some families. Some of the Project families have rather negative feelings about agencies (particularly in matters of authority clashes with such agencies as Children and Family Services). They do not trust the schools and they do not want their children labeled "handicapped." In addition, they do not want to become involved with "the University," the home base for the Macomb Project. The mobile unit effectively becomes the territory which is relatively safe and neutral. Both fathers and mothers are interested in the unit and its equipment, while the child is attracted to the materials which are child-sized and interesting. As Project staff work with these families within the mobile unit, it is usually only a matter of time before family members become more trusting of the staff and their helping intentions.

One of the first steps in the delivery of services in the Project is medical stabilization of each child. The mobile unit is sometimes used to provide transportation to physicians' offices, public health clinics, and medical centers for diagnostic work and inoculations when no other form of transportation is available. This works particularly well when there are several children from the same area who are scheduled for a Crippled Children's clinic.

The mobile unit also transports several sets of children and their parents (when feasible and necessary) to bi-weekly sharing centers located in centrally located churches or community buildings throughout the service area. Sometimes it is used to transport families to the weekly water activities program at the YMCA. Afterwards, it is used as a site for snacks and parent discussion.

Travel to nearby conferences, workshops, and in-service sessions is often scheduled in the mobile unit. The members of the staff of the Macomb 0-3 Regional Project are continuously upgrading their knowledge and expertise in the fields of Early Childhood/Early Childhood Handicapped Education, as well as in specialized areas such as cerebral palsy, Down's Syndrome, and visual and hearing impairments. While traveling in the mobile unit, members of the staff are able to plan programs, develop curricular ideas, or work on budget. The unit also serves as the site of periodic staff retreats, enabling the entire Project staff to confer away from the interruptions of jangling telephones, drop-in visitors, and students in need of help.

A further use of the mobile unit is the provision of on-site screening and evaluation of children. Perhaps the simplest form of screening available in the mobile unit is the basic audiological evaluation conducted by a Child Development Specialist trained or assisted by an audiologist. A portable audiometer may be readily installed in the mobile unit. Impedence bridge testing may be conducted on-site, eliminating the need for long delays in scheduling appointments at a speech and hearing clinic. The Macomb Project is fortunate to have both cooperation and participation from the university speech and hearing clinic, where trained professionals who are easily available are anxious to obtain experience with handicapped infants and toddlers. A diagnostic team can travel in the mobile unit, providing developmental evaluations. An occupational therapist also works in the mobile unit, traveling around the rural area and working with children who live in widely scattered locations. The mobile unit is a good site for all such activities.

"Specs" for the Mobile Unit

The mobile unit used by the Macomb 0-3 Project is a Jamboree Motor Home (E-Model 22) on a Dodge chassis. It was selected in part because of the competitiveness of the price ($12,000 in 1975). The company was also willing to make special modifications for the Project. Modifications included the installation of a small bathtub for bathing infants, a diaper/laundry receptacle, a full length door mirror, and special child-proof screen door and ignitor switches on the gas/electric refrigerator and heater.

Before the mobile unit was purchased, the co-directors of the Macomb Project investigated many different types of vans and campers. They sent for promotional materials before submitting a purchase order to the business office of Western Illinois University. The unit originally included a small bathroom with toilet, sink, and small bath tub; a small kitchen with range, sink, small refrigerator; an area with two built-in seats and removable table; a small furnace, and an air conditioning unit that is run on an auxiliary generator.

After the mobile unit was used for five months, remodeling was undertaken. The original brown shag rug was removed and indoor-outdoor carpeting was installed. The carpeting was donated by a wholesale carpet dealer in Peoria. One of the built-in bench seats was removed to make more floor space. A child-sized bean bag chair was added, along with an unbreakable mirror which can be attached to the wall at child height. The interior of the unit is darker than it should be. The paneling is a dark wood tone, and upholstery is brown and white plaid. The addition of lighter colored carpeting and interesting bright pictures, along with open curtains to let in more light, is helpful. Since the remodeling was accomplished by Project staff and one other person outside the Project, the costs were minimal ($116.45). If all the work had been done by outside workers, remodeling costs would have been much higher.

Other adaptations, after the mobile unit was purchased, included lettering which was painted on the side of the vehicle by a local high school student. His charge was ten dollars. An 8-track tape deck was adapted for cassette tapes through the installation of a converter. During the second year of the Project, a CB radio was purchased in order to provide communication capability for the staff members using the vehicle in remote rural areas. The CB radio was purchased at a discount and installed in the unit by one of the co-directors. Request for federal licensing was made and readily obtained. The staff requested "Baby Buggy" as the CB "handle" and this motif has since become the Project's logo for dissemination purposes.

Maintenance for the Mobile Unit

Supplies necessary for efficient day-to-day operation include L.P. gas, paint, a fire extinguisher, and a space heater. The latter item was necessary during the severe winter of 1977 in order to maintain enough heat to keep pipes from freezing. (The mobile unit is too tall to be housed in the university garage, so must sit outside all year round, plugged into an electrical outlet especially erected for it.) Other items needed include duplicate sets of keys for all Project staff, pans, towel racks, a plexiglass mirror, deodorizer, paper products, and the small bean bag chair.

Normal maintenance on the mobile unit includes regular lubrication, oil changes, and periodic tune-ups. (These services were performed by the university garage at no cost to the Project.) Water tanks must be filled from time to time, and waste dumped when necessary. The early onset of the harsh winter of '76-77 caused undrained water pipes to burst and necessitated replacement of pipes and water pump. The voltage cover was replaced, as was the L.P. gas gauge.

The Jamboree Averages 8.45 miles per gallon in highway and country road driving. Since the Project is affiliated with Western Illinois University, the charge for gasoline was computed at 10¢ a mile for the first two years, 12¢ a mile for the third year, the established state university rate. Other transportation is also used by the Project. State university cars are used frequently, in addition to the mobile unit. Gasoline charges for these vehicles was figured at 8¢ a mile for the first two years, and 10¢ a mile for the third year.

Operational Costs

Costs for operating the mobile unit may be found in Table 1. During the three years, the mobile unit traveled a total of 23,927 miles. Other vehicles were used for a total of 20,181 miles during the three years. Usually the mobile unit is taken by a staff member who is scheduled for home visits in rural areas for a full day at a time. It is used almost every day. For the three years, direct operating costs were $3991.51. When other costs such as installation of the electrical outlet and various supplies were added, along with depreciation over the three-year period as determined by appraisal in June, 1978, the total operational cost was $5161.71.

Table 2 contains information about the cost per mile over three years. The average cost per mile for operating the mobile unit over a three-year period, excluding the original purchase cost, is $.2157 per mile.

Table 1. Operational Cost of a Mobile Unit during the 3 Years of the Macomb 0-3 Regional Project, a Rural Child/Parent Service.

	First Year Planning 7/75- 6/77	Second Year Operational 7-76 - 6/77	Third Year Operational 7/77 - 6/78	Total Three Years Combined
Mileage	2201	11,019	10,707	23,927
A. Direct Operating Costs				
1. Gasoline	220.10	1101.90	1284.84	2606.84
*2. Repairs and Servicing	56.37	465.14	377.16	898.67
3. Insurance	162.00	162.00	162.00	486.00
B. Equipment and Accessories				
1. Electrical outlet installation	150.00	--	--	150.00
2. Major Supplies	59.85	171.94	--	231.79
3. Minor Supplies	22.53	35.93	29.95	88.41
C. One-time-only Expenditures				
1. Remodeling	116.45	--	--	116.45
2. Initial Cost	12,000.00	--	--	12,000.00
D. Total Costs				
1. Direct Operating Costs (A)	438.47	1729.04	1824.00	3991.51
2. Equipment and Accessories (B)	232.38	207.87	29.95	470.20
3. Direct Operating Costs (A) plus Equipment and Accessories Cost (B)	670.85	1936.91	1853.95	4461.71
4. Depreciation	--	--	--	700.00

*Routine repairs and servicing are done by the university garage at no cost to the Project.

GRAND TOTAL $5161.71

Table 2. Costs Per Mile for Operating the Mobile Unit during the 3 Years of the Macomb 0-3 Regional Project, a Rural Child/Parent Service*

	First Year Planning 7/75 - 6/76	Second Year Operational 7/76 - 6/77	Third Year Operational 7/77 - 6/78	Average Cost for Three Years
Direct Operating Costs (includes gasoline, repairs, service, insurance)	$.1992 per mile**	$.1569 per mile	$.1704 per mile	$.1668 per mile
Direct Operating Costs plus cost of equipment and accessories	$.3048 per mile	$.1758 per mile	$.1732 per mile	$.1865 per mile
" " " " plus depreciation	--	--	--	$.2157 per mile

* Initial purchase cost and remodeling costs are not included in these figures

** See Table 1 for total mileage and breakdown of expenses.

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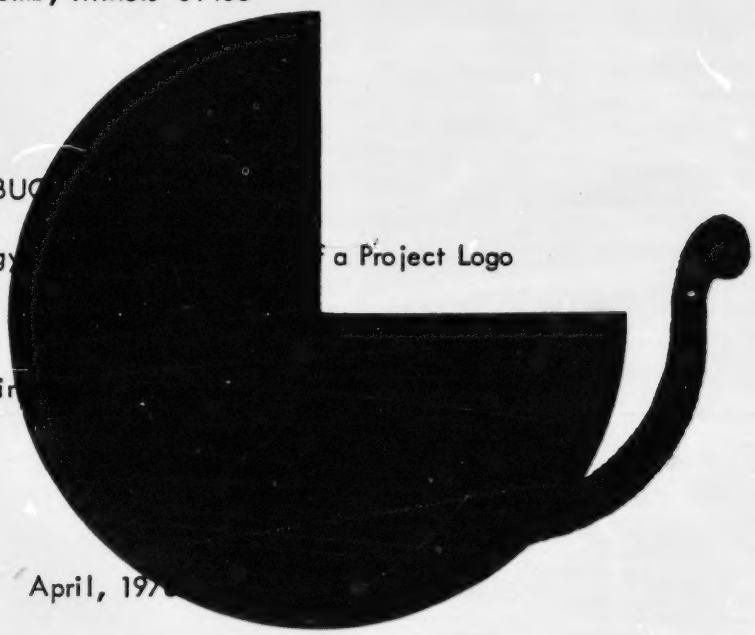

BABY BUG

The Story of "Baby Buggy ... a Project Logo

Patricia L. Hutin...

April, 197...

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USOE-BEH Grant No. G00-75-00234 Project No. 44 AH 50417

One of the first tasks faced by an HCEEP project in its first year is that of beginning to develop dissemination materials to "spread the word" regarding the project's activities. The Macomb 0-3 Regional Project met that task through the development of a unique logo, the Baby Buggy, which has been the unifying element for a series of Baby Buggy papers, Baby Buggy Books, and other materials for Project dissemination. The logo is closely related to the Project's delivery strategy which makes use of a mobile unit in rural areas. The mobile unit has a citizens band (CB) radio--and the handle for the CB is "Baby Buggy." From that somewhat inauspicious beginning, the Baby Buggy logo has developed into the colorful symbol for advertising and marketing the Project's dissemination packages and strategies.

The Baby Buggy now firmly identifies the Macomb 0-3 Regional Project, a third year demonstration project in the Handicapped Children's Early Education Program funded by the Bureau of Education for the Handicapped. The Project, located at Western Illinois University in Macomb, Illinois, is a rural project which provides services for the education/remediation of handicapped and high risk children from birth to three years of age, and to their families. Because the families live in a widely scattered pattern throughout a three-county rural area, a major part of the Project's delivery strategy is use of the mobile unit, a "room on wheels" which travels around the countryside.

The mobile unit, a modified Jamboree Motor Home, is used in a variety of ways, and is, of course, the subject of at least one Baby Buggy Paper! The Baby Buggy provides not only transportation to the homes for the Child Development Specialists (CDSs), but also is a space for on-site home visits. The mobile unit is often used as a model demonstration area for work with child and parent. It can be used to hold small sharing centers for two Project families who live close together. In a sharing center, parents, children, and siblings gather together with the CDSs to take part in developmental activities and educational experiences. The mobile unit can also provide transportation to physicians' offices, public health clinics, and medical centers for diagnostic work and inoculations when no other form of transportation is available.

The CB radio was installed after several rather harrowing experiences in winter weather on remote country roads. The CB was a necessary means of communication for the CDSs when they were traveling in the mobile unit. When one of the CDSs suggested "Baby Buggy" as a "handle" for the CB, half jokingly, we all laughed! Upon further reflection, the Co-Directors decided that it might provide the descriptive, easily-recognizable symbol they had been searching for, particularly after a TADS conference on dissemination.

At that conference in October, 1976, a media consultant strongly advised the Macomb 0-3 Project to develop a unique logo, suggesting that the CB "handle" provide the creative stimulus. Although the Project staff laughed as they thought about a series of Baby Buggy papers, work was commenced on developing the Baby Buggy logo. Drawings of baby buggies of various sizes and shapes filled page after page. Ideas came from all sides, and soon the format for Project stationery, cover sheets, and posters was finalized. The design was developed by the Project, without the help of a paid artist.

Because the stationery and cover sheets were designed to stand alone, as a title page, with some lettering, or to serve as the first page for letters or material almost covered with printing, they are multipurpose. The first stationery came back with a coral colored baby buggy design. After consultation with the printer, the Project Director was able to get him to agree to run the sheets through again, using the bright orange ink originally planned. Most printers consulted did not want to place such a bright color on the page, where they thought printing of a message might also occur. The final bright orange and yellow, or bright orange and white pages have been colorful and easily used for many purposes. The first order included the design in letter weight paper in two colors, and in heavy weight cover sheets.

The Baby Buggy was off and rolling, not only in its original form as a mobile unit whose sides identified the Project vehicle on "hard roads" and dirt roads throughout west-central Illinois, but also in a variety of dissemination products generated by the Project staff. Baby Buggy letterhead stationery was used to print newsletters to parents and the general public; posters were made to advertise Project-sponsored in-services; even typically bland covers for BEH proposals and progress reports soon were replaced by the ever-rolling baby buggy cover sheets, now laminated to both look better and hold up longer.

From the first year, a series of working papers were initiated which explained various Project components. With the advent of the Baby Buggy logo, those papers became Baby Buggy Papers. They are numbered according to a classification system, so that a 100-level paper is one which deals with an aspect of Delivery Strategies; 200 deals with Parent Participation; 300 deals with Staff In-Service; while 400 deals with Personnel. The series of working papers now encompasses a variety of topics of interest to other parent/infant educators. Topics include toilet training, parent and staff bibliographies, language development, use of a mobile unit in a rural project, water activities, and toy workshops for parents.

Two Baby Buggy Books, a sharing center curriculum and a booklet of ideas for activities using common household items, were produced in 1977. A third one, describing home visit procedures, is in production. The potential for more and varied dissemination products using the Baby Buggy logo would seem unlimited.

Baby Buggy has evolved from a casual remark by a staff member into an easily recognizable, colorful and pertinent logo which identifies the Macomb 0-3 Regional Project. What's more, the wheels keep turning . . . .

Macomb 0-3 Regional Project
April, 1978

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Activity Pl

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June, 19

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USOE-BEH Grant No. G00-78-01853 Project No. 444-BH 80067

The Child Development Specialists (CDSs) of the Macomb 0-3 Regional Project make weekly, bi-weekly, or monthly home visits to Project children. For each visit, an activity plan is made.

The activity plan is a list of the experiences that are to be provided for the child during the course of the home visit. In order to provide activities at the child's developmental level, the CDS conducts an assessment of the child's abilities. Assessment includes the Alpern-Boll Developmental Profile, the Receptive-Expressive Emergent Language Scale, and (in children under 18 months) the Hunt-Uzgiris Ordinal Scales of Psychological Development, along with a systematic observation of the child in his environment.

Based upon the assessment scales and systematic observation of the child, the CDS complies a list of goals to be accomplished by the child within a period of six months. These Bi-Yearly Goals, taken from the Project's Core Curriculum cover all areas of development with emphasis on areas where the child shows greatest delay. (For a sample of the format for Bi-Yearly Goals used by the Macomb 0-3 Project, see Attachment A. A copy of the Core Curriculum can be found in Baby Buggy Paper #163.)

The Activity Plan

An activity plan is written for each home visit the CDS makes. (For a sample of an activity plan and the goals used as guidelines, see Attachment B.) When the CDS plans activities for a home visit, she uses the Bi-Yearly Goals as a guideline. One or two goals from each developmental area are used along with several goals from the area of the child's greatest delay.

There are several points that the CDS must keep in mind as she plans a child's activities. First, the child's specific handicaps (delays) must be considered. An activity should be somewhat challenging, yet within the child's range of competence. A child should not be expected to perform an activity that is well beyond his developmental level. Providing too difficult an activity is not challenging to the child, it is only frustrating. Second, the activity should accomodate the child's attention span. A complicated, involved activity is not appropriate for a child with a short attention span. Also, a toy with many parts may be overstimulating to a hyperactive child. Third, the toy used in the activity must appeal to the child with whom it is being used. For instance, an infant would probably not be interested in plain wooden blocks.

After the activities have been planned, several items are added. One is a list of the materials to be used during the home visit; this list makes packing for the visit much easier. Points to be discussed with the parent should be noted. Techniques for working with the child, reading materials for the parents, and future appointments with specialists are among the items that might be included.

Macomb 0-3 Regional Project
June, 1978

The Long Term Goal program is the final item to be included in the activity plan. This program is an individual charting process wherein the parent keeps a daily record of the child's progress in a given activity. (For a more detailed explanation of the Project's Long Term Goal program, see Baby Buggy Paper #157.)

Implementing Activity Plans

When the CDS begins to pack for the home visit, she uses the activity plan to insure that she gathers the correct toys and materials. The list of toys and materials written on the activity plan makes the preparation for the day's visits much easier.

After the toys for each child have been packed, the activity plan is put with them so that it can be used as a guide during the home visit. The CDS refers to it for activities, reading material to be left with the parent, points to be discussed with the parent, and toys to be left for the child to use until the next home visit.

Finally, when the CDS returns from her day's home visits, she evaluates the activity plan and the home visit using the space provided on the activity plan form. The CDS writes her observations of appropriateness of the activity, how the child interacted, what the parent did, what the CDS did, whether the child liked the activity, and so on. Comments should be short and to the point, including only the statements that the CDS feels are pertinent to the evaluation and to planning further activities for the child. (See the evaluation section of the Activity Plan, Attachment B.)

The activity plan is helpful to the CDS in many ways. It provides a guide for activities to be used during the home visit. It is also a checklist of toys and materials which makes preparing for the home visit easier. In addition, it serves as a reminder to the CDS of items to discuss with the parent during the home visit.

Attachment A
Bi-Yearly Goals 2-78

Area	Goal	Number
Fine Motor	The child places pegs in pegboard.	05/05/00
	The child removes pegs from pegboard.	05/06/00
	The child builds a tower of five or six blocks.	05/01/01
	The child makes a vertical mark on paper.	05/08/01
	The child strings several beads.	05/02/01
	The child holds crayon with fingers.	05/09/01
	The child turns pages of a book.	05/10/00
Gross Motor	The child squats, maintaining balance.	04/10/01
	The child catches large ball with hands and body.	04/11/01
	The child walks up and down stairs using rail, alternating feet.	04/12/01 04/13/01
Cognitive	The child points to eyes, nose, mouth, and feet.	06/01/01
	The child points to named object.	06/04/00
	The child does simple puzzle formboard.	06/02/00
	The child follows simple commands of one and two parts.	06/05/00
Language	The child names ten familiar objects.	07/04/00
	The child uses pronouns me, my, and mine.	07/05/00
	The child points to or places object above, below, front, back, around, or through.	07/06/00

ATTACHMENT B

ACTIVITY PLAN

Child's Name_____ CDS_____ Date:_____

Child with general delay, especially fine motor.

MATERIALS	ACTIVITY	EVALUATION
Beach Ball Popcorn Drop Cloth Cake Pan Bowl Glass Measuring Cup Spoon Scoop Tactile Mat Pegboard Toy Car Small Ball Stuffed Rabbit Book Apple Pictures of: Car Ball Rabbit Book Apple Book: TODDLERS & PARENTS (For Mom) Building Blocks	Gross Motor Goal: The child rolls a large ball while seated on floor. 04/03/00* Goal: The child throws a large ball three feet in a specified direction. 04/14/00* Activity: Play with beach ball; encourage rolling and throwing. Fine Motor Goal: The child pours from one container to another. 05/27/00* Activity: Take popcorn and containers for exploration and play. Goal: The child removes pegs from pegboard. 05/06/00* Goal: The child places pegs in pegboard. 05/05/00* Activity: Jumbo pegs all colors with tactile pegboard for parent and child to put in and take out pegs. Cognitive/Language Language Goal: The child names familiar objects. 07/04/00* Cognitive Goal: The child points to named object. 06/04/00* Activity: Using real objects and pictures of the objects, the child and parent point to, name, and talk about them. Use ball, car, rabbit (bunny), book, and apple. Then give child apple for self-feeding experience.	Gross Motor Mom got involved. Child verbalized Rolling ball went well, throwing didn't-child not ready. Fine Motor Activity 1: Child poured with little spilling - Good! Popcorn got all over. Child tried to eat it Use shovel and bucket sometime? Activity 2: Child didn't like. Could pull pegs out; Got frustrated trying to put them in. Mom tried to help but child wouldn't (or couldn't) accomplish task. Cognitive/Language Went well. Language coming along. Especially liked apple. Let child play with toys. Got more vocalization that way.

*Core Curriculum Number.

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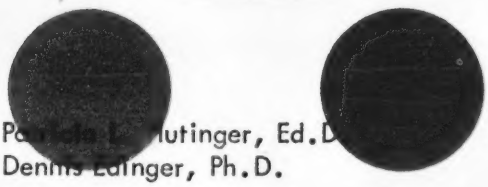

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Toilet training a child is not as upsetting for parent and child as it may have been in the past. Gone is the idea that a mother is a failure if her child is not out of diapers by his first birthday. Now, both parents can work together in a positive, natural way to train their child - or more accurately - to help him train himself.

How do you know if your child is ready to begin toilet training? Age alone can't provide the answer. Some children are successfully trained by the age of two, while others are not ready until much later. There are some clues your child may give you that he is ready for training.

One clue is your child's ability to hold urine. When diapers are dry after two or more hours, or when you can predict several times during the day that he is likely to urinate, he may be ready for training. The child's muscles must be developed before he will be able to hold urine until he is on the toilet.

Establishment of bowel movement patterns may also indicate your child's readiness for training. Generally, children establish habits for bowel movements between their first and second year. When you as a parent note this pattern, place your child on the toilet at the appropriate time in anticipation of the bowel movement. This eliminates the "dirty" diapers before the child has been completely trained. Care must be taken, however, to make this a positive experience. If it is not, the child may hold back stools and become constipated. If you notice this behavior, discontinue the practice temporarily.

Third, the child must be able to communicate a desire to go to the toilet, either with gestures or words. It is up to you, the parents, to look for these signs and to act upon them.

Finally, a child must know what a toilet is and show an interest in toilet habits. This may be picked up from observation of other family members using the toilet, or by explanation and encouragement from the parents. Make sure the child knows what he is supposed to do, but never pressure him into doing it. Let him know that the toilet is there for him to use <u>when he is ready</u>.

There are other indications that a child may be ready for toilet training. One is being able to sit quietly and play for a period of time. This will occur after the child is over the excitement of learning to walk and run. Another indication is the child's use of imitative behaviors - copying adult actions such as brushing teeth or doing dishes. Third, as mentioned before, is the child's ability to understand what it means to need to go to the toilet and why he should wait until he is on the toilet to urinate. Finally, the child must not be in a negative period. He should not have a temper tantrum every time you ask him to do something.

The parents' attitude toward the child and his toilet training is one of the most important factors in the success of the project. Be positive and encouraging to make the training experience as pleasant as possible for you and your child. If necessary, provide something for the child to do while he is sitting on the toilet. However, it is important not to make the toilet just another play area. This can be avoided by reminding the child frequently what you want him to do, and by taking him off the toilet after five or ten minutes.

Use reinforcement if needed. Reinforcers should be immediate and desirable. Suggestions for appropriate reinforcers are play-time with parent(s), praise, or use of a special toy. Food and drink should not be used for reinforcement. The child becomes dependent on the reward, and it is difficult for the parent to eliminate it from the training pattern. Also, negative reinforcement should NOT be used; for example, "If you don't go to the toilet, I'm taking your truck away." This only leads to anxiety and frustration in the child, and will probably make training more difficult and upsetting.

The most effective attitude that you as parents can have is to be firm but patient. Don't let the child manipulate you, but don't let him become frustrated either. This is difficult, but necessary. It is easier if you work with the whole child, not with just the training program and the child's ability to succeed. Naturally, the child will have accidents. Don't get upset about them. Just get him changed and attempt to avoid these accidents in the future. You might remind him periodically that it is time to go to the toilet. This is especially needed when the child is playing outside. He will often get involved in play and forget about going to the toilet until it's too late. It might also be helpful to keep an account of what happens immediately before a child has an accident. If accidents are frequent, or if they begin to occur after you thought your child was trained, the events immediately preceding the accident may provide a clue to the problem.

During the toilet training period, make a special attempt to keep attacks and stress on the child at a minimum. Any anxiety or frustration he feels may be directly reflected in his toilet habits. Work patiently on any emotional problems the child has. When they are solved, toilet training will be much easier. Above all, be consistent. A child who knows what is expected of him, and who is secure in the knowledge that things aren't going to change, will be willing to cooperate and try to please his parents.

Staying dry all night is a big step in the training process. However, night training should be left until after the child has been clean and dry during the day for a long time. The child will usually indicate when he is ready to give up the night diapers, so don't press him. When a child is ready, talk to

him about it before bedtime. Then, wake him up before you go to bed to see if he is willing to take himself to the bathroom. Carrying him to the bathroom while he is asleep will not help train him. When he can get himself to the bathroom alone during the night, he is just a small step from getting himself up early in the morning to urinate if necessary.

The above method of toilet training a child is by no means foolproof. Rather it is a suggested guideline to be adapted to your child's individual needs. Patiently working with a child in a consistent manner, accepting him as he is, will make the toilet training experience easier and more pleasant for everyone concerned.

Bibliography

Brazelton, T. Berry, M.D. "Toilet Training: A New Step-by-Step Approach." Redbook. May, 1973, pp. 80+.